# Wisconsin Department of Safety and Professional Services


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**MEDICAL EXAMINING BOARD**

## JOINT COMMISSION CERTIFIED HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

The **State of Wisconsin** requests Joint Commission Certified employers to complete this form for all hospitals, facilities, and where the below physician currently has or previously held staff privileges, or employment during the last five (5) years. **You must answer all of the following questions and provide any additional information in order for this form to be considered complete.**

PHYSICIAN'S NAME: _____

NAME/LOCATION OF FACILITIES: Please attach a complete list of all facilities where the above physician has had employment or staff privileges under your employment. List should include the name of the facility, location (city/state), and dates employed (mo/yr-start/end). The list should be given in alphabetical order.

JOINT COMMISSION CERTIFIED EMPLOYER NAME: _____

JOINT COMMISSION CERTIFIED EMPLOYER ADDRESS:

_____

JOINT COMMISSION CERTIFIED EMPLOYER TELEPHONE #: ___ - ___ - ____

JOINT COMMISSION CERTIFIED EMPLOYER ORGANIZATION NUMBER: Submit your number in the spaces below.

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JOINT COMMISSION CERTIFIED EMPLOYER EMAIL ADDRESS: Submit your email address in the spaces below.

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| | | YES | NO |
|---|---|---|---|
| 1. | Has your entity received Joint Commission Certified certification? | ☐ | ☐ |
| 2. | What position does the physician hold under your employment? _____ | | |
| 3. | List the physician's dates of employment or staff privileges under your employment: __/__/__ to __/__/__ | | |
| 4. | Did the physician either leave your employment in good standing or is currently employed and in good standing? **If no, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 5. | Was the physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment**? If yes, please provide explanation on a separate sheet and attach to this form.** | ☐ | ☐ |
| 6. | Was the physician granted a leave of absence while employed at any of your facilities or under your employment? **If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |

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| | | YES | NO |
|---|---|---|---|
| 7. | Did this individual have a record of unexcused absences during his/her attendance at any of your facilities or under your employment? **If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 8. | Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees or staff holding similar positions? **If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 9. | Were any restrictions placed on this physician's privileges? **If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 10. | Were any formal patient or staff complaints filed against this physician**? If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 11. | Was the physician denied hospital privileges while employed by you? **If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 12. | Were any incident reports filed involving the professional conduct or behavior of the physician**? If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 13. | Was the physician ever subject to non-routine monitoring while at your facility? **If yes, please attach explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 14. | Was the physician involuntarily removed from a call schedule for cause**? If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 15. | Was the physician subject to non-routine quality assessment review? **If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |
| 16. | Was the physician the subject of a negative review by a quality assurance or departmental committee**? If yes, please provide explanation on a separate sheet and attach to this form**. | ☐ | ☐ |

PRINT NAME AND TITLE OF JOINT COMMISSION CERTIFIED EMPLOYER/OFFICIAL SUPPLYING INFORMATION:

SIGNATURE OF JOINT COMMISSION CERTIFIED EMPLOYER/OFFICIAL SUPPLYING INFORMATION:

_____

DATE FORM WAS COMPLETED**:** ☐☐ / ☐☐ / ☐☐

**JOINT COMMISSION CERTIFIED EMPLOYER, RETURN THIS FORM DIRECTLY TO:**

DSPS
ATTN: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may also fax /email with facility cover sheet /letter to: (608) 261-7083 or DSPSCredMedBD@wisconsin.gov.